Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING; 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		This 45		B. WING		04/0	04/06/2042	
TN1915								
WINDOWS AND DELIABILITATION M. 431 LARK			DORESS, CITY, STATE, ZIP CODE KIN SPRING RD					
4 3 1 1 7 Let 1 7 les h	- ,		MADISON	I, TN 37115	,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
N 831	1200-8-608 (1) Building Standards			N 831				
	 (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the overall physical condition of the nursing home environment. The findings included: On 4/8/13 at 10:50 AM, observation within room #33 revealed the exhaust fan grille was missing from housing unit in the ceiling. 2. On 4/8/13 at 10:50 AM, observation within room #22 revealed the resident bathroom wall was damaged by a wheel chair. 				N 831 Building Standard 1. Room #33 exhaust far been replaced. 2. Room #22 resident be the point of entry has 1 3. Room # 12 bathroom 6	throom wall at	May 10, 2013	
					repaired. These repairs will the QA/IDT team 2013 meeting.	oc reviewed		
				[) ~			
		10AM, observation wasident bathroom ento wheel chair.						
	Administrator and v	e acknowledged by t rerified by the Mainto exit interview on 4/8,	nance					
N 901	1200-8-6-,09(1) Life	e Safety		N 901				
	required applicable regulations at the ti codes or regulation compliance is main	me which complies of building and fire safted adopted in the board adopted will, so long as such tained (either with or	ety s new ch			•		
ANT TO GOISTVIK	ealth Care Facilities	The A			TITLE		(X8) DATE	
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESEN	TATIVE'S SIG		Administrator		5/4//3	
STATE FOR	VI			0800 A	V6\$O21	if continue	ilan sheet 1 of 3	

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Division of Health Care Facilities Ligarity Title Construction (X3) Date survey									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MIDE STATE CONSTRUCTION			COMPLETED			
AND PLAN	OF CORRECTION	IDEN HEIGATION NU	MOEN.	A, BUILDING: 01 - MAIN BUILDING 01		1			
				- 11714		04/08/2013			
	TN1915			DDRESS, CITY, STATE, ZIP CODE			J8/ZU13		
NAME OF P	ROVIDER OR SUPPLIER								
431 J.ARK			RKIN SPRING RD IN, TN 37115						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE I COM			
N 901	Continued From page 1			N 901					
	waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.						May 10, 2013		
	Based on testing a	•	as I the	N 901 1200-8-6-09 Life Safety 1. Night light in room #22 has been replaced. All night lights in the facility have been checked and are operating. 2. Night light in room #12 has been					
	1. On 4/8/13 at 11:15 AM, testing and observation within room #22 revealed the night light was not working. 2. On 4/8/13 at 11:37 AM, testing and observation within room #12 revealed the night light was not working.				replaced and all night light facility have been checked operating. These repairs will be rewith the QA/IDT team at 2013 meeting.	l and are eviewed			
	Administrator and	re acknowledged by verified by the Mainto exit interview on 4/8	enance						
N1111	1200-8-611(4)(h) Records and Reports		N1111						
	of the following red months following to maintained in a sin available for inspen	ome shall retain legible cords and reports for heir issuance. They igle file and shall be ction during normal be in who requests to vi	thirty-six shall be made ousiness						
	(h) Maintenance recare equipment.	ecords of all safety a	ind patient						
	according to the m	enance shall be adm anufacture 's recon le above equipment.							

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Division	of Health Care Faci	lities			AGUSTINATION	(X3) DATE S	URVEY	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		R/CLIA	(XZ) MILLIFEL COMOTION		COMPLETED			
AND PLAN	OF CORRECTION	DENTIFICATION NU	MBEK:	A. BUILDING: 01 - MAIN BUILDING 01)	1	
	TN1915		•	B, WING			04/08/2013	
		1111313	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			RKIN SPRING RD				
KINDRED NURSING AND REHABILITATION-M/ MADISON			MADISON	, TN 37115			(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE C E APPROPRIATE		
N1111	Continued From page 2			N1111				
•	Ensure that facility staff or contract personnel are appropriately trained to conduct safety and patient care equipment inspections.						May 10, 2013	
				i	N1111 1200-8-6-11 Records and I	Reports		
				ļ				
	This Rule is not met as evidenced by: Based on records review, it was determined the facility failed to maintain records on serviced equipment. The finding included: On 4/8/13 at 9:30 AM, records review revealed the boiler license had expired since 1/8/13. This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 4/8/13.				Contact with the Boilers and Eleva division of the state licensure office copy of the current boiler license whe issued and this was done. Curre inspection certificate is now on file. This correction will be brought to the team during the May 2013 meeting	ice, another was asked to rent boiler ile. the QA/IDT		
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